**Psychiatric Diagnostic Evaluation**

Agency Name
Agency Address

**Identifying Information**

Name: Age:
Ethnicity: Gender:
Medicaid Number:
Individual(s) present:

Service Rendered:
Setting of Service:
Start Time: End Time: Duration:
Service Provider:
Date of Report:

**Assessment Protocol**

Identify sources of assessment information
Identify psychological screening and assessment instruments used

**Chief Complaint/History of present illness**

Reason for the assessment referral
Client's perception of the problem(s)

**Psychosocial history**

Developmental History
Social History
Current state of functioning

**Family history**

Family constellation
Family history
Family relationships
Current state of family functioning

**Psychiatric History**

Mental health treatment history
Prior mental health diagnoses
Current mental health status

**Medical History**

Medical History-surgeries, illnesses, ABI/TBI etc.
Allergies

Current Medication(s)
Present state of health

**Substance Abuse History**
Substance(s) abused,
Frequency, intensity and duration of use

**Educational and Vocational History**
Schools attended and GPA
Learning disabilities and strengths
Educational aspirations

Employment history
Career interests and aspirations

**Legal History**
Record of offenses
Placement History
Risk and protective factors

**Mental status exam**
Appearance, Motor, Speech, Affect, Thought Content, Thought Process, Perception, Intellect, and Insight.
Mini Mental Examination score

**Screening and assessment instruments administered**
Identify the screening and assessment instruments administered
Document screening and assessment instrument scores and results

**Diagnostic Impression**
DSM V diagnosis (including codes and specifiers)

**Assessment Summary**
Summarize assessment findings
Summarize client prognosis
Make specific treatment recommendations

**Licensed Therapist Signature:** Date:
Include credential and title

**Clinical Supervisor Signature:** Date:
Include credential and title (If necessary)